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	Page		Page		Page
ORIGINAL LECTURES.		REPORTS OF HOSPITALS.		N. Y. PATHOLOGICAL SOCIETY:	
Spermatorrhea, being a Lecture delivered at the College of Physicians and Surgeons during the Session of 1863-4. By Willard Parker, M.D.	265	U. S. GENERAL HOSPITAL, CENTRAL PARK, N. Y. Surge B. A. Clements, U.S.A., in Charge. Dislocation of Thigh into Thyroid Foramen reduced by Manipulation. Service of Dr. Geo. F. Shrady.	270	Stated Meeting, January 13, 1864. Dr. D. S. Conant, President, in the Chair. Aneurism of the Ascending Aorta, etc., etc.—Aortic Aneurism and Aneurism of the Left Coronary Artery.—Disease of the Aortic and Mitral Valves.—Mitral Direct Murmur.	272
ORIGINAL COMMUNICATIONS.		BELLEVUE HOSPITAL:		EDITORIAL ARTICLES.	
Report of Sixty Cases in Prof. Noeggerath's Clinic for Diseases of Females, at the N. Y. Medical College. With Remarks by C. C. Terry, M.D.	266	Fractures of the Leg.	271	Meeting of the American Medical Association.	273
On Strabismus. By Henry D. Noyes, M.D.	267	REPORTS OF SOCIETIES.		Transfer of the Severely Wounded.	274
Two Cases of Extirpation of Polyp in the Larynx. (With Woodcut Illustrations.) By Friedrich Semeleder, M.D.	269	NEW YORK ACADEMY OF MEDICINE:		Our Contents.	274
		Stated Meeting, May 18, 1864. Dr. James Anderson, President, in the Chair. Cancer of the Rectum.—Fistula in Ano.	273	Pay of Acting Assist.-Surgeons.	274
				REVIEWS.	
				Transactions of the Illinois State	
				Medical Society for the Years 1861, '62 and '63.	275
				CORRESPONDENCE.	
				Fredericksburgh.	275
				ARMY MEDICAL INTELLIGENCE.	
				Circular Letter.	276
				General Orders No. 193.	276
				Orders, Changes, etc.	276
				MEDICAL NEWS.	
				METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.	
				SPECIAL NOTICES.	

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Original Lectures.

SPERMATORRHOEA,

BEING A

LECTURE DELIVERED AT THE COLLEGE OF
PHYSICIANS AND SURGEONS

DURING THE SESSION OF 1863-4,

By WILLARD PARKER, M.D.,

PROFESSOR OF THE PRINCIPLES AND PRACTICE OF SURGERY AND SURGICAL
PATHOLOGY.

GENTLEMEN:—I propose to offer you a few remarks upon the subject of spermatorrhœa, because I am convinced of the importance of your understanding something concerning the characters of this common and oftentimes vexatious malady. Spermatorrhœa may be defined as an involuntary discharge of semen, associated with dreams, and of course occurring at night. I shall consider the subject under two heads. First, I shall refer to that form which occurs in full health, and is the result of a purely physiological condition of the system. Under the second head I shall consider that form which is the result of exhaustion of the nervous system, associated with a local irritation in the prostatic portion of the urethra. This local difficulty is denominated irritable urethra, in contradistinction to urethritis or an inflammation of that canal.

First, as regards the spermatorrhœa of health. In order to supply the physiological wants of the system we have given us certain appetites. For example:—Individual life must be preserved, and we have hunger; the species must be taken care of and propagated, and we have sexual desire. When the stomach desires food the vessels of the great cul de sac, as well as those of the cardiac orifice, become congested, and the sensation which is thus produced, the desire for food, cannot be appeased until something eatable is actually placed into the stomach. If the person goes to bed hungry this sensation, reflected to the brain, will cause him to dream of eating, and during his sleep he will make away with many a palatable dish and many a delicious viand. The occurrence of seminal emission, during sleep, can be explained in the same manner. The natural desire for sexual intercourse not being indulged in, causes a plethora of the seminal vessels, the sensation is referred to the brain during sleep, when it is least able to resist such impressions, and the imagination easily manufactures a dream to suit the emergency. If a person indulges more or less regularly in intercourse with a female, as in married life, the necessity for these emissions does not exist. I believe the great mass of men, after arriving at full puberty, have these emissions more or less frequently, the average being about once in from two to four weeks. If a person's system is any way overtaxed he is not so liable to be subject to these emissions as if he were in the enjoyment of healthful leisure and full diet. It is strictly a physiological process, as is shown from the fact that the nervous system is thereby simply *relieved* rather than *depressed*. This, however, is not the case with the pathological spermatorrhœa, which we shall next consider.

When this flow of semen is very frequent, and is attended with symptoms of impairment of health, then it comes to be a disease.

The causes of this disease are both predisposing and exciting. Under the head of predisposing causes I may mention that some systems are more prone to suffer from it than others; for instance, we meet with it most commonly in the nervous and lymphatic temperaments.

The exciting causes may be summed up under the following heads:—1. Masturbation; and I may say in passing, that the earlier this habit is begun the more serious will be the consequences. 2. Excessive venery. 3. Occupation of the mind by lascivious subjects and improper associations. 4. Hæmorrhoids and constipation. 5. Asca-

AM. MED. TIMES, VOL. VIII., No. 23.

rides. 6. Eczema, with its attendant itching. 7. Stricture of the urethra; and 8. Full bladder.

The symptoms, too, naturally divide themselves into local and constitutional.

The local symptoms are few; you have of course the emission, and, besides, there is considerable pain in the situation of the caput gallinaginis, as is proved by the introduction of an instrument. When the instrument passes through the prostatic portion of the urethra, the suffering is sometimes intense, actually causing the patient to scream out. It will be found, too, in almost every case, that, if the finger be introduced into the rectum while there is at the same time a bougie in the urethra and the prostate compressed, there will exist there an undue sensitiveness, and that sensitiveness will be found to extend upwards and backwards to the vesiculæ seminales. The constitutional symptoms are as follows: General prostration of the whole nervous system, manifested by an aversion to physical and intellectual exertion; a dull pain in the back and front part of the head; also pain in the loins, feebleness of the memory, pallor of the face, more or less of a sunken eye, skin quite cold, hands and feet clammy, capillary circulation feeble, aversion to society, hypochondriasis, indigestion, and constipation. The urine is often copious and watery, of low specific gravity, feeble acid reaction, and loaded with phosphates. Sometimes in the urine there are found spermatozoa. In the evacuation of the bowels, especially if they are constipated, the pressure of the feces upon the vesiculæ seminales squeezes out a fluid which the patient regards as pure seminal juice; it is, however, mostly an excess of secretion from these vesiculæ seminales, there being usually but a few spermatozoa contained in it. The immediate cause of this abnormal flow of semen is due to the very irritation which is present at the termination of the ejaculatory ducts, and excites the secretion of the testicles. We see this principle illustrated very often in the case of irritation of Steno's duct, the secretion of the parotid gland being largely increased in consequence. Again, if any irritating substance be taken into the stomach and passed undigested into the duodenum, we know that not unfrequently an excessive flow of bile is induced, which gives rise to the very common complaint, cholera morbus. And after all, gentlemen, what is this cholera morbus due to? The irritating substance, as it passes down the duodenum, comes in contact with the opening of the ductus communis, and an irritation is produced there; that irritation is reflected to the gland, which in this case is the liver, and the superabundance of bile is thrown out, and you have the cholera (the flow of bile). The irritation at the caput gallinaginis being the cause of the spermatorrhœa, you will of course be prepared to appreciate the value of the local applications to these parts which are made use of for the cure of the difficulty.

The diagnosis of the affection is, in the main, not difficult, the patient being generally only too willing to tell you of all his troubles.

Now, Gentlemen, we come to speak of the prognosis. I may say that ordinarily the prognosis is good, more especially when the patients are made aware of the character of the difficulty, and take proper measures to overcome it. But if the causes still remain and are not properly looked after, the system becomes enfeebled both intellectually and physically, the whole character of the individual is changed, the true objects of life become perverted, and a goodly number of these become the subjects of our lunatic asylums, either as confirmed hypochondriacs, maniacs, or idiots. Understanding, then, that one of the most fruitful causes of pathological spermatorrhœa is masturbation, we can comprehend how it is that this vicious habit becoming more and more confirmed, drags down the nervous system into a condition which amounts to a species of insanity.

I am quite certain that a very large proportion of these cases can be saved from such a sad condition if the subjects be fully apprised of the danger and injury of such a debasing habit, and occupy the energies of their mind in pro-

per intellectual pursuits, and their bodies in vigorous outdoor exercise. I may say, in passing, that all kinds of treatment and medication, without the above course, are comparatively inoperative or unavailing.

Sometimes connected with spermatorrhœa there is impairment of the vigor and force of the generative capacity, and patients often in this depressed condition of the system fall into a state of mind which is mono-maniacal upon the subject of virility. Every surgeon must be more or less teased by this class of patients, some of whom will not be convinced as to the error under which they are laboring. But of this we shall speak more in detail as we proceed.

Having, then, duly considered the different characters of this disease, we shall be prepared to study its treatment.

(To be continued.)

Original Communications.

REPORT OF SIXTY CASES IN PROF. NOEGGERATH'S CLINIC FOR DISEASES OF FEMALES, AT THE N. Y. MEDICAL COLLEGE.

WITH REMARKS
By C. C. TERRY, M.D.

THE following tabular statement presents the character and frequency of the diseases observed in these cases:—

Insufficient development of the uterus.....	3	Uterine hemorrhage.....	4
Superinvolution.....	3	Amenorrhœa.....	5
Subinvolution.....	3	Dysmenorrhœa.....	14
Endometritis.....	1	Vicarious menstruation.....	2
Perimetritis.....	3	Sterility.....	3
Metritis.....	3	Epilepsy.....	1
Ovaritis.....	2	Hysteria.....	1
Ovarian cyst.....	1	Anæmia.....	3
Hydrometra.....	1	Chlorosis.....	2
Fibroid tumor.....	3	Vaginal catarrh.....	2
Cancer uteri.....	2	Vulvar catarrh.....	2
Anteflexion.....	5	Vulvo-vaginal catarrh.....	1
Retroflexion.....	4	Pruritus vulvæ.....	2
Anteversio.....	2	Cystocele.....	2
Lateralversio.....	5	Catarrh of Cowper's glands.....	1
Retroversion.....	3	Abscess of recto-vaginal septum.....	1
Descensus uteri.....	3	Varicose dilatation of pelvic veins.....	1
Prolapsus.....	2	Cystic catarrh.....	3
Constriction of cervical canal.....	2	Cutaneous neuralgia.....	2
Cervical catarrh.....	7	Infra-mammary pain.....	10
Inflammatory hypertrophy of cervix.....	1	Mammary secretion.....	2
Follicular hypertrophy of cervix.....	1	Secondary syphilis.....	2
Erosions, excoriations, and granulations of the os.....	9	Cerebral congestion from scanty menstruation.....	1
		Fluctuating abdominal tumor.....	1

INSUFFICIENT DEVELOPMENT OF THE UTERUS—EPILEPSY.

I. Margaret C., æt. 21 years, native of Scotland, unmarried. Menstruation commenced at 15, and occurred three times at regular intervals of a month, then entirely disappeared, and remained absent nearly three years. Re-commenced at 18, and continued a year with no nervous disturbance. Epileptic attacks then made their appearance at irregular intervals, commencing with muscular spasms in the right hand, the aura passing thence to the head. Nausea and intense cephalalgia continued more than an hour after the momentary attack. From the first the menses were exceedingly scanty, being a mere "show," with a great deal of dysmenorrhœa, continuing but three days at the most. A moderately firm hymen closed the posterior two-thirds of the ostium vaginae. The uterus was little more than the prepuberal size, very movable, the cervix projecting into the vagina, and presenting the characteristic nipple shape. The sound entered the narrowed canal of the cervix with difficulty, and showed the dimensions of the uterine cavity contracted in all its diameters. The most constant symptoms were cephalalgia of the right side, and shifting pains in the lumbar and right iliac regions.

II. Helen B., æt. 26, native of New York, has been married eight years, but without becoming pregnant. She

began to complain of vague symptoms soon after marriage, expressing her condition as "feeling poorly." Constipation and tympanites were specially distressing. Menstruation commenced at about 16, and continued at regular intervals; but the duration was short, usually only half an hour, and the quantity inconsiderable. The uterus was found healthy but of small size, movable, with a nipple-shaped cervix and minute os externum. A considerable and constant pain in the abdomen had existed almost since marriage, and the quantity of urine voided was excessively increased before and after the menstrual discharge.

III. Mary C., æt. 23, unmarried. Menstruation commenced at 18, and continued at regular intervals of about four weeks, lasting but two or three days at the most, merely a show. From the first she has suffered great dysmenorrhœa, so that at each period she "would rather be dead." Added to this were cephalalgia, dizziness, backache, pain of a burning character in the hypogastrium and left iliac region. The patient was a stout, plethoric servant girl, accustomed to labor, but of late unable to retain a situation on account of her frequent illness and increasing stupidity. She was also subject to habitual constipation. The external genitals were fully developed, ostium vaginae admitting a good-sized speculum, and vagina capacious. Uterus small, dense, very movable; the cervix high and forming a conical projection into the vagina; the os not distinguishable by the touch. The speculum showed the vagina of normal vascularity, the cervix pale, the os a mere dot at the apex of the cone, and so small that the ordinary pocket probe could not be introduced. When its introduction was attempted, the bulbous point barely entered the orifice, and the uterus moved away out of reach.

In these three cases of the so-called incomplete development of the womb, neither uterus presented the foetal shape, but all were pear-shaped, with shortened conical cervixes; in fact differing from the fully developed adult uterus, by a deficiency of all their diameters and a denser consistence. All were in females of otherwise good development and appearance, and could be traced to no constitutional disease. In the first and third, the cerebral function had evidently suffered severely, as evidenced by the epilepsy of the one, and the confusion of the other. While the first remained taciturn, yet capable of sensible and connected conversation, the other was constantly running into a disconnected and scarcely intelligible discourse, interrupted occasionally by a peculiar unmeaning smile.

Abundant experience has shown that the suffering and symptoms presented by these patients, are directly referable to an insufficiency of the menstrual secretion; hence the indication in these cases was two-fold:

- 1st. To increase the secreting surface;
- 2d. To increase the secretion.

In order to effect the first of these objects—increase of the secreting surface, advantage was taken of the general law which prevails in uterine therapeutics as well as in uterine pathology and physiology, viz. "Continuous and increasing irritation and expansion of the uterine cavity or uterine walls leads to increased growth of the organ and of its cavity;" for if there be any hypertrophy of the uterine parietes, it is readily indicated by the enlarged cavity. No matter whether that body be a growing ovum, a polypus, a fibroid tumor, an hydatid, the accumulation called hydrometra, a blood-clot, or the ordinary dilating sound, the same law holds good, although the irritation and dilation, to be successful, must be employed frequently, and often for a considerable time. A very small uterus, and especially a uterus whose development has been not only imperfect but irregular, would make the prognosis less favorable than a regularly though somewhat imperfectly developed uterus.

In the first case no other treatment than the sound was used. The first introduction was somewhat painful and caused a little irritation; but each succeeding application, at intervals of several days, grew less irritating, and the canal gradually enlarged to the normal size. The sound

was allowed to remain in the uterine cavity for twenty or thirty minutes each time, and the patient was required to rest a few hours after each introduction. Gradually the epileptic attacks lessened, and finally ceased altogether. The countenance brightened, the menses appeared in full quantity, the symptoms one after another yielded, and in less than five months she was perfectly recovered, save an occasional headache, which however was of little moment. In the third case more difficulty was experienced. The smallness of the cervical canal and the patient's reluctance caused much delay. The constipation yielded to a mild electuary; the cervical canal became sufficient to admit the ordinary sound; the pallor and hardness of the uterine tissue gave place to a more normal color and consistence; two menstrual periods passed with very great relief; and the patient expresses herself as "a great deal better." The second case was ordered powdered cubebs.

The remarkable circumstance in this was the increased urinary secretion at each menstrual crisis, constituting a "metastatic or vicarious menstruation." This is one of the less common manifestations of menstrual digression, and deserves notice as being one of the many succedanea by which the vascular system rids itself of its periodic superfluity. It is not always easy to determine whether an abnormal quantity or quality of secretion or effusion from a tissue or organ, be vicarious menstruation, or the result of some pathologic condition of the part engaged. At all events, amenorrhœa and periodicity of such phenomena, combined with an examination of the part involved, will usually determine the question. Periodic hæmorrhages from the nose, rectum, vulva, ears, ulcerated surfaces of the cervix uteri, gums, and even the skin, with no diseased condition of the parts engaged, have undoubtedly occurred, not only in chlorotic and plethoric persons, but also in females of apparently good health, who have had some form of amenorrhœa. Epistaxis is probably the most common form of hæmorrhage connected with suppressed menstruation. Various mucous surfaces take on increased action at periodic intervals corresponding with the menstrual crises; thus the bronchial and intestinal mucous membranes pour out an excessive quantity of their peculiar secretion; the vagina becomes catarrhus, and the renal secretion, as in the case before us, becomes much augmented. Although the period of life at which menstruation commences is widely different in different individuals, depending upon a variety of causes, we may conclude, from Dr. Whitehead's analysis of 4000 cases, that the average age is about fifteen years and seven months, the variation being usually from twelve to eighteen years. Insufficient development of the uterus is regarded as a frequent cause of tardy menstruation. The first and second of the above cases commenced before 16, the other at 18. Sterility is not a necessary consequence of abnormal development of the uterus, provided the other essential organs are competent. Pregnancy has taken place before the exceedingly tardy menses appeared in the small uterus, in the unicorn uterus, and even a twin pregnancy in a uterus bicornis.

(To be continued.)

ON STRABISMUS.*

By HENRY D. NOYES, M.D.,

SURGEON TO THE NEW YORK EYE AND EAR INFIRMARY.

(Continued from page 256.)

THE questions to be settled before the operation are, is sight imperfect—can it be improved? If yes, the squint can be perfectly corrected. If not, we must be content with partial success. In the former case we restore binocular vision, in the latter we obtain an improvement in personal appearance.

The only successful mode of treatment is the division of one or more muscles. All other attempts by glasses and diaphragms are of no value. The operation is not the division of the continuity of the muscle; it is cutting the tendon

from its insertion, and causing it to adhere to a point further back on the sclerótica. Division of the belly of the muscle, or at any point behind the insertion, results in extreme shortening, and perhaps renders it impotent to move the globe. The bit of tendon remaining attached, does not grow again to the posterior portion, but shrivels up, and the remaining part either grows fast to the globe very far back, or may slip into the capsule of Tenon and be able to act on the eye only by the medium of this fascia. A brief allusion to the anatomy will explain this, and show that this was the great error of the early operations for squint.

The oculo-orbital fascia, when reflected from the wall of the orbit, passes behind the globe in a cup-like form. The globe rests in this cup as the head of the femur in the acetabulum. The muscles and nerves perforate the ocular portion of the fascia in their passage to the eye. The muscles carry with them some of the fibrous membrane, which gets thinner as it passes forward, and finally is lost as the sub-conjunctival areolar tissue. The distance between the point where the muscles perforate the fascia, or capsule of Tenon, and their insertion into the globe, is from $\frac{1}{2}$ to $\frac{3}{4}$ inch. It is evident that the further its insertion is carried backwards, the weaker is the muscle made. It is shortened, and its contractibility made less effective, and its power is also exerted to less advantage, because the sine which represents its mechanical power is shorter. (Illustrated by diagram.)

How should this tenotomy be done? So as to separate the muscle with little disturbance of the fibrous tissue around it. A simple tenotomy can only be done with small scissors and a small hook. I use these instruments: hooks of three sizes, curved at right angles, the tip probe-pointed; scissors straight, small, and the points ground off; fine clawed forceps. I do not think it material whether the conjunctival wound is made vertically or horizontally, provided it be small, not more than a quarter of an inch long. I make it just in advance of the insertion of the tendon, and vertically; run the scissors backwards to cut the areolar tissue overlying the tendon, then pass in the hook with its point downwards if designing to pass under the lower border of the muscle; keep it close to the sclerótica, and when far enough back, turn it upon the tip and slip it under the muscle; drag the insertion into view and cut the tendon between the hook and the globe. All the insertion is not severed at the first clip, but have another hook ready to take up the remainder of the insertion; holding the eye in command by the first hook, divide what is caught by the second, and thus sever the whole insertion. Such a tenotomy can be managed so as to produce not more than $1\frac{1}{2}$ or 2 lines alteration in the visual axis. It is well, before the operation, to measure the deviation upon the border of the lower lid. Here is a measure contrived for this purpose; its middle point is applied to the centre of the palpebral opening, and the point upon it, which is reached by the centre of the pupil, gives the amount of squint in lines. The tenotomy I have described may, by cutting the adjacent fibrous tissue, be made to effect a correction of 3 lines.

It is not safe to push the effect of one operation too far. Too free incisions will render the muscles utterly unable to influence the eye. If the squint be more than 3 lines, the correction must be divided between the two eyes. This is a point of difference between present and former practice. Since the purpose of operating is to restore equilibrium, it would not seem just to do all the subtraction of force on one side.

I can, however, demonstrate this, by the aid of this diagram. I suppose a converging squint of the right eye, of about 4 lines, expressed by its angle amounting to about 55 degrees. At this point the turning power of the right rect. int. is not equal to that of the left rect. int., because the lever on which it acts is so much shorter than that of the other eye. The lever, or the line which represents its mechanical power in the left eye, is the radius of the circle,

* Read before the New York Academy of Medicine, March 2, 1884.

and continues to be, until the eye turns in to the point where the insertion of the muscle becomes a tangent. In the right eye, the line which measures its power is no longer radius, but is the sine of the arc included between its insertion and the point of impact on the circle, of the line which unites the centre of motion to the origin of the muscle. This is the sine of the arc and is less than radius, because the arc is less than 90° . Now, suppose the whole correction of the squint is put upon the left eye. The insertion of the muscle is let back until the visual axis is parallel to that of the other eye. The insertion goes to this point. What happens? In movements towards the left side, the right rectus internus is at a great disadvantage; its turning power is represented by a very short sine, while the left external rectus has radius for its turning power. Moreover, the left rectus internus, by slipping back, has brought its two extremities nearer together, and it has less contractile power. This defect appears again in efforts at convergence; hold up the finger at five or six inches from the face; the short sine of the right side contrasts painfully with the full power of the left, and, as a consequence, the right eye ultimately gives up the effort and lapses into divergence. By dividing the effect between each eye, since the right rectus internus is hypertrophied more than the left, it will bear a greater reduction in mechanical advantage than the left, and the two internal recti will then be able to do their work harmoniously.

In strabismus of 5 or 6 lines, both eyes may be operated on at one sitting. For 3 lines it is better to give an interval of two or three weeks, that the effect of the first operation may be correctly known. The effect is less during the first week, than during the succeeding month or two. After this, the effect is again increased. This corresponds to the primary healing, the contraction of the cicatrix, and its final relaxation. For converging strabismus of more than 8 lines, three operations may be needed—two on one eye and one the other. For diverging strabismus, I have twice had to do four operations—two on each external rectus. The effect of tenotomy on the external is not so great as on the internal rectus.

When the cure is partial, vision being good, the patient complains often of double images. By the help of prisms you can determine the angle of deviation yet remaining, and get a hint as to the extent of a subsequent operation.

If the patient have *hyperopia*, the cure is not complete, nor will it be permanent, if convex glasses be not used in reading, writing, sewing, etc. The necessity for glasses depends on the degree of hyperopia and the power of accommodation. In a person over 20 years, I should give glasses if the hyperopia be more than + 20. For a person below 20, the hyperopia might be + 10 and glasses not needed to prevent relapse of convergence. But always warn such persons that a tendency to relapse of squint means the necessity of wearing convex glasses, and that, irrespective of age. For astigmatism, cylindrical glasses.

In myopia the rule cannot be applied with equal force, because many of these patients have impaired perceptive power from atrophy of the choroid and retina; and other disadvantages attend the employment of concave glasses for near objects. If, however, the perceptive power be good, and there be no lesion of the choroid, weak concave glasses will aid the muscles in keeping the advantage they have gained by division of their antagonists.

I do not think it well to operate under five years of age, because young children cannot give accurate data about their sight.

I have supposed improvement of sight to be possible. If, now, this be not the case; if one eye be greatly defective, and the operation is desired to improve its position, do not promise to make both eyes "perfectly straight," as the phrase is; but you may safely promise a decided improvement. Aim, if there be convergence, to leave a little remaining, the visual lines meeting at the distance of six or eight inches when viewing things at moderate distances. A slight convergence is scarcely noticed, but a little diver-

gence is very disagreeable. If the operation be for divergence, operate so freely as to convert it into slight convergence, performing the operation on both eyes. By this proceeding, cases will be left in a more satisfactory condition, and surgery will not have the censure of making a deformity worse than it was before.

If the effect of a tenotomy is greater than was anticipated, it may be retrieved by putting a stitch into the loosened end of the muscle and fastening it to the conjunctiva. This may be done immediately after the operation, or even the next day. If chloroform is used it occasions loss of time, and, to ascertain the result, you must wait until its effect has passed away. To test the effect of the operation for converging squint, see if the patient can still converge both eyes to the finger held within six inches; if he cannot fix steadily at this point, the operation has been too free; then put in the suture. A more accurate test is the study of double images and what prism he is able to overcome. If you have operated for converging squint, and the patient have diplopia in seeing near objects, and the images be crossed, then put in suture. So, too, if the conjunctiva has been widely opened and there is danger of the caruncle sinking, put a stitch obliquely through the wound and pucker up the conjunctiva.

From a large conjunctival wound granulations sometimes sprout; they may be snipped off with scissors.

Treatment of insufficiency of the internal recti is for slight cases by prisms, when their angles need not be more than 8° . If more serious, tenotomy of the external recti, partial or complete, will regulate the matter.

For *lucitas*, division of the antagonist is practised, but the result is not pleasant; the eye springs forward out of the orbit, and it remains fixed and staring. If any power remain in the paralysed muscle, it may be helped in its function by bringing its insertion farther forwards—just the reverse of tenotomy. Dr. SIMROCK, of this city, has practised this operation a number of times. I have done it. It consists in first dividing the antagonist, and then separating the paralysed muscle at its insertion, dissecting it up freely, passing a thread transversely through it; then, having a needle at each end, carry the ends of the thread under the conjunctiva, around the margin of the cornea, and come out of the conjunctiva at the opposite side of the cornea; then pass one needle back again and run it through the conjunctiva at the wound, and tie the thread firmly. The conjunctiva is drawn up over the cornea like the mouth of a purse, and the muscle is pulled forwards. The sclerotic needs to be laid bare in front of the tendon of the muscle, up to the edge of the cornea, and the muscle must be loosened from its attachments to the fibrous tissue. It grows fast in its new location in twenty-four to forty-eight hours. At the time of operation the antagonist muscle is also separated. The thread may be left in situ for that time without serious reaction. Pretty smart inflammation, perhaps with chemosis, does not destroy the good effect of the operation. Its beneficial results are sufficient to warrant its performance in such cases as have reached the period when medical treatment and the vis medicatrix nature have nothing more to offer. This will be in, say, twelve months after the original paralysis. I could relate a most interesting case in which I performed this operation, and also divided four other muscles, to cure a partial paralysis of the superior and internal recti of the right eye. The result was very satisfactory.

Lastly, we are sometimes called upon to rectify the errors of former surgery, in attempting to restore an eye to its normal position which has been badly operated on and the muscle has lost all control over the eye. I have seen some painful cases of divergence following operations for the cure of convergence. I have operated three times under these circumstances. In one case nothing could be seen of the cornea of one eye, and the glaring sclerotic presented a ghastly appearance.

The relief of this condition is by searching for the extremity of the divided muscle, and the dissection is always diffi-

cult, loosening it from surrounding adhesions and drawing it well forwards; denude the sclerotic in front of the muscle of the conjunctiva that it may grow fast, and the next step is to retain the muscle in place. When there is but little of the muscle left, too little to permit the attachment of a suture, as in the operation of Dr. SIMROCK, the method which Mr. CRITCHETT and Prof. GRAEF use, is to be chosen. Expose the tendon of the opponent muscle; pass a thread transversely through it and tie it fast, then cut the tendon behind the thread; this gives command over the eye; now carry the thread to the opposite side of the face and fasten it there by sticking-plaster. I have always operated for the benefit of the internal rectus, and have once passed the thread leading from the tendon of the external through the skin of the nose and tied it. The eye must be kept in this position for twenty-four hours, and more, if reaction do not prevent. An excessive correction of position as the immediate result need not create anxiety. The eye begins to turn back very soon, and I have found the ultimate condition a decided improvement. There is, of course, diminished mobility, but the arc of movement has been brought around to the useful position. If the operated muscle has long been disused, it may have atrophied or undergone fatty degeneration, so as to be unable to contract; but it is right to give it a trial.

I think I may be allowed to conclude after this somewhat elaborate discussion, that the operation for strabismus, properly estimated and rightly performed, should not be abandoned, but deserves a place among valuable surgical operations. The deformity is to be regarded no longer as always constituting the essential disease, but frequently only a symptom of visual disturbance. The operation may be done, either for its own immediate results alone, or as ministering to a nobler result in the restoration of sight. A quarter of a century has, therefore, brought the operation for strabismus to higher dignity and usefulness than its originator propounded.

TWO CASES OF EXTIRPATION OF POLYPI IN THE LARYNX.

(With Wood-cut Illustrations.)

By FRIEDRICH SEMELEDER, M.D.,

OF VIENNA.

[Translated from the Vienna Medizinal Halle, by EDWD. T. CASWELL, M.D., of Providence, R. I.]

(Continued from page 258.)

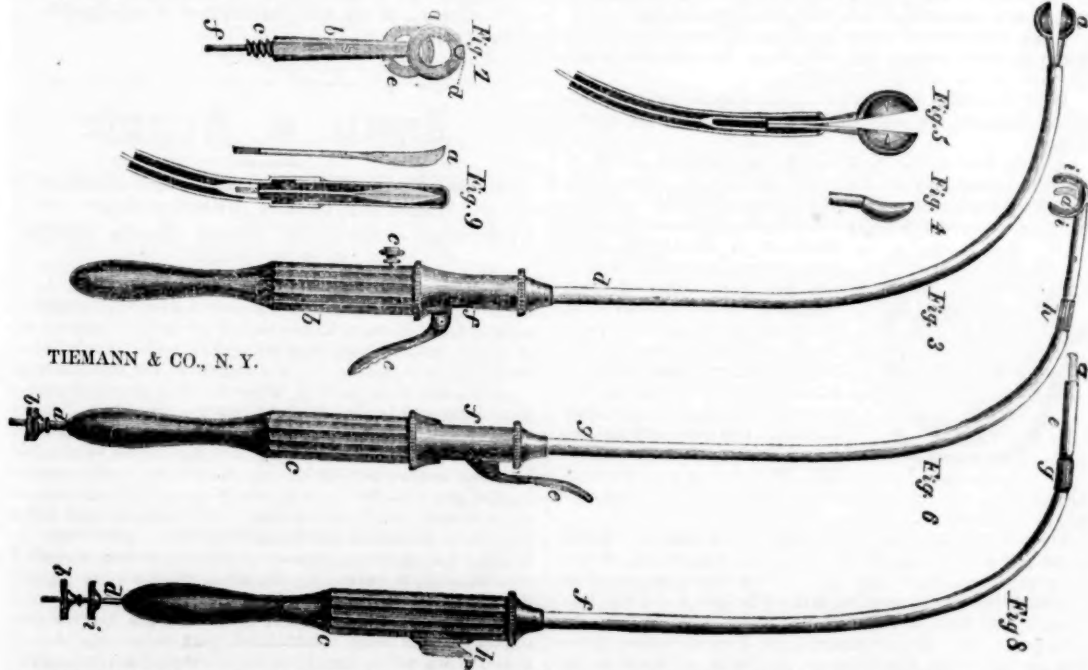
THE instruments which I have hitherto applied to operations upon polypi in the larynx are three—the forceps, a guillotine, with a sickle-shaped knife, and, finally, an instrument so arranged that any one of several blades may be introduced, the blade being at the same time concealed. As these instruments have rendered good service, I will devote a few words to their explanation. Joseph Leiter, Instrument Maker and Bandagist, No. 76 Alser street, Vienna, can furnish any of them.

I. LEITER'S LARYNGEAL FORCEPS

(Fig. 3, two-thirds of the actual size), is the result of manifold alterations and improvements.

The Spring forceps *a*, when closed, resembles the half of a hollow sphere; the cutting edges, which shut upon one another (Fig. 4) are dull. Each blade of the forceps has in its concavity a spear-point which does not extend beyond the cutting edge. At the end of the spring the forceps terminates in a screw-thread (Fig. 5, actual size) of six millimetres in length; by means of this the blades are firmly screwed into a little tube at one end of a wire, the other end of which is firmly held in the handle *b* (Fig. 9) by the screw *c*. The metallic tube *d*, which can be bent if necessary, moves over this wire and is shoved forward by pressure upon the lever *e*, and thus the blades of the forceps close quickly. When the lever *e* is freed from pressure, the tube *d* is driven quickly back by a spiral spring placed within the box *f*, and thus the forceps are readily opened. The cutting edge of the forceps *a* can be turned so as to seize a polyp in any direction. If the instrument is to be taken apart the blades *a* must first be unscrewed, then the screw *c* loosened, and thus the wire will be set free, and finally the milled head of the box *f* must be unscrewed.

The rounded sickle-shaped knife invented by me (Fig. 6, two-thirds of the actual size), is intended to take the place of Bruns's scissors. It may be applied in any direction.



TIEMANN & CO., N. Y.

The blade *a* (Fig. 6), like the forceps in Fig. 5, is fastened to a wire, the end of which, passing through the handle *c*, is fastened by the screw *b* to a tube *d*, which moves in the handle. By a spiral spring concealed in the handle *c*, the tube *d* is pressed against the short fork-like end of the lever *e* which lies in the box *f*. The blade *a* is covered by a double two-leaved sheath *g*. Both leaves of the sheath are attached to a round tube, which terminates in a screw-thread fitting into the double screw *A*. This double

screw *A* is fastened to, and turns upon the end of the tube *g*, which is stationary but which may be bent. If pressure is applied to the lever *e* the knife slides suddenly out, and is again covered by the leaves of the sheath. When the double screw *A* is unscrewed, the blade may be turned in any direction, just as in the case of the forceps *a* in Fig. 3; then the blade being held by its sheath in the left hand, the double screw is again tightened with the right, and the instrument is ready for application.

Fig. 7 is a double ring between the leaves of which a ring-shaped blade plays. This contrivance, resembling the Tonsillotome, may be screwed on to the instrument, Fig. 6, instead of the sickle-knife, and it may be manipulated in the same manner. In Fig. 7, *a* represents the double ring, *b* its stem with its screw *c*; the two rings are held in place on the one side by the clamp *d*, and on the other by the screw at *b*; *e* is the knife drawn down, and *f* its terminal screw.

The instruments, Figs. 6 and 7, may be taken apart by unscrewing first the cutter, then the lever, and finally the screw *b*.

Neither the guillotine nor the sickle-shaped knife is provided with the spear for piercing a polyp. I have stated above the injurious effect which these spears may produce, and I think we attach altogether too much importance to the falling down into the air passages of a small polyp or a fragment of one. The experience of Moura-Bourouillou confirms my opinion. He removed a small polyp from the vocal chord by means of a wire sling; on the end of the instrument there was a small arrow-head for piercing the tumor. But he had reckoned without the host, and the tumor fell into the trachea; it did not, however, cause the slightest inconvenience. In the case of larger formations this point would demand greater consideration, but in all such cases neither of these two instruments would come in question.

Fig. 8 (two-thirds the actual size) represents Leiter's covered knife, which may be applied in all directions, and into which cutting instruments may be introduced, either probe-pointed or lancet-shaped, or like an ordinary scalpel.

The attachment of the blade to the wire is accomplished as shown in Fig. 9 by a screw. The wire to which the blade is attached moves in the tube *f* and also in the handle *c*, in which it is fastened to the tube *d* by the screw *b*. The tube *f* is attached to the handle and does not admit of motion, but it may be bent. At its other extremity it has a contrivance for changing the direction (Fig. 9) like the one in the preceding instrument; only here the tube *e*, which is slit in front, serves as a sheath for the blade *d*. In Fig. 8 the double screw *g* holds the sheath fast. Fig. 9, *a* represents a scalpel-blade which may be introduced. The tube *d* is kept down by a spiral spring placed in the handle *c*, and thus the blade is kept concealed in the sheath. By shoving forward the slide *h*, which is screwed on to the tube *d*, the blade is driven forwards. The screw *i* serves to regulate the protrusion of the blade. The instrument may be taken to pieces by unscrewing first the knife, then the screws *b* and *i*, as well as the slide *h*, and finally the tube *f*.

The tubes of all these instruments are colored black, so as not to interfere with the reflex image in the mirror.

I can recommend these instruments from my own experience, and I believe that with these the operator would be quite well provided for all cases.

CASE II.—The case here recorded may indeed be considered as one of the most difficult for laryngoscopic operation.

A lady (her age I did not ask), a governess, came to me last autumn to be examined and to ask my advice. She had suffered for five years from complete aphonia, which had been gradually developed. On a careful examination, I discovered three formations of various sizes, as in Fig. 10. The largest of these was spherical and was seated in the vicinity of the left vocal chord; a second, smaller and club-shaped, projected from the anterior angle of the glottis, and lay with its free extremity upon the first; the third and smallest protruded from the anterior surface of the right arytenoid cartilage, at about the level of the vocal chord, and extended into this latter structure.*



FIG. 10.

I stated to her that I was inclined to operate; that I could not insure success, so far as the restoration of the voice was concerned; but that by the operation, even as regarded the voice, nothing was to be lost, since she was already voiceless, a circumstance sufficiently unfortunate for a governess. To my amazement, I must confess, there was no dyspnoea, not even an abnormal murmur to be heard on auscultation.

(The author goes on to state that the patient had been examined by two laryngoscopists, one of whom made the

diagnosis, but at a time when the formation was not so large, and considered an operation impracticable; the other, however, looked forward to an operation at a later date. The lady had also been advised by another physician to go at once to London or Paris, where he thought she might long ago have been freed from her polyp; while in point of fact, up to that time, no laryngoscopic operation had been undertaken in either of those cities.—Tr.)

The formation had at first, from its pale, reddish-yellow color, from its dim lustre, and from its uneven raspberry-like surface, led me to regard it as an enchondromatous or a fibroid tumor, but as I studied it more carefully with reference to a future operation, I found by the aid of the sound that it had something of the consistency of flesh, and, finally, I concluded that it must be composed of areolar tissue. The largest of the tumors proceeded, as I have said, from the left side of the ventricle of the larynx, and covered the left vocal chord in such a manner that only a small portion of the posterior part of the chord could be seen; this fragment seemed to have a normal appearance. The anterior extremity of the left vocal chord was covered by the polyp No. 2. As the patient was so sensitive under the examination, I could not determine whether the polyp No. 1 lay free upon the left vocal chord, or whether it was intimately connected with it. When the glottis was closed all three of the polypi were shoved over each other. Thus much, however, I could observe. By the attempt to utter sounds, the polyp No. 1 was rolled up around its broad basis, so that it would then lie upon the right vocal chord, and would be wedged in between the ventricular and the vocal chords of both sides. The polypi Nos. 2 and 3 proved to be quite freely movable, following the respiratory current; No. 2 particularly, with its free end glided down over No. 1, and was again thrown upwards by a forcible expiration.

The patient, aside from this local trouble, was apparently in perfect health, and there were no reasonable grounds for supposing a connexion between the local disease and any cachexia, or for the preëxistence of any special disturbing cause.

(To be Continued.)

Reports of Hospitals.

U. S. GENERAL HOSPITAL, CENTRAL PARK, N.Y.

Surgeon B. A. CLEMENTS, U.S.A., in Charge.

DISLOCATION OF THIGH INTO THYROID FORAMEN REDUCED BY MANIPULATION.

SERVICE OF DR. GEO. F. SHREADY.

THE following case of dislocation into the thyroid foramen is reported, not so much on account of its rarity of occurrence or of any original plan of treatment that was instituted, as for the sake of adding to the statistics of the accident:—

A. B., German, private, while walking at night over a tressel railroad bridge, fell between the sleepers, a distance of forty feet, and was rendered insensible. When he recovered, he found himself lying at the foot of one of the hollow main supports of the bridge. He was soon after assisted to rise, and after being temporarily cared for, was sent to the hospital. On being carefully examined, he was found to present the following symptoms:—The right lower extremity was everted, advanced before its fellow, abducted, rotated slightly outwards; the knee and hip being slightly flexed. He was capable of moving the thigh only to a very limited extent, and there was noticed a marked prominence at the inner upper third, just below the flexure of the groin, while, instead of the usual prominence created by the trochanter, there was the characteristic flattening of the hip. The swelling on the internal aspect of the thigh was hard and globular, and over its most prominent portion, the tendon of the adductor magnus muscle stood out distinctly. The foot maintained its natural relations

* For convenience of reference these will be designated respectively as Noa. 1, 2, and 3. [Tr.]

to the line of the limb. There was a good deal of aching pain along the whole outer aspect of the thigh. The patient being etherized, Dr. Shradley proceeded, forty-eight hours after the accident, to reduce the dislocation in the presence of, and with the assistance of Drs. Clements and Fernandez.

Extension was first made in the line of the limb, and the thigh was gradually flexed upon the pelvis to a point opposite the centre of the thigh of the opposite side, when the limb which had been kept abducted was rotated inwards. The head of the bone then slipped into the acetabulum. During the latter part of the manipulation the head of the bone was crowded firmly outwards by pressure with the hand. The two extremities were then bandaged together, a thick compress being placed between the thighs high up. The patient was kept confined to bed for seven or eight days, at the end of which time he was allowed to use his lower limbs cautiously. At the expiration of fifteen days he was able to walk about without the aid of a crutch, and with but a slight halt.

The patient did not recollect in what position he was at the time he recovered his senses; he might have been prone or supine, and in either condition it would be somewhat difficult to judge as to how the injury was inflicted. It is probable that he either struck upon his feet, with his legs spread apart, or else falling feet foremost, his legs also being abducted, the right one during his descent struck against some of the projecting bars which formed one of the main supports of the bridge.

The lower and internal portion of the capsular ligament must of course have been torn, and the round ligament severed. It was not necessary to use any undue force in the reduction, as the head of the bone, after a little coaxing, followed the usual course around a small segment of the inferior rim of the acetabulum, being finally tilted into that cavity by rotation and adduction of the limb.

BELLEVUE HOSPITAL.

FRACTURES OF THE LEG.

We do not propose to write the history of any given number of cases of this accident, but merely to describe the method of treatment which at present holds the precedence in this hospital. Various splints have been employed, and the experience thus accumulated has produced a decided partiality for certain surgical appliances, and also disabused us of the idea that every fracture of the bones of the leg may be successfully treated by any single apparatus; for the practical surgeon is often obliged, in particular cases, to exercise his best judgment in the selection and application of some one of the approved dressings.

For most simple fractures of the tibia and fibula, uncomplicated with any very serious lesions, we prefer some material which can be made pliable by moisture or heat, and in this condition moulded and secured to the limb, so that when it dries or cools, a firm, accurately fitting splint is obtained, which meets all the indications of this class of cases. This may be accomplished with sole leather, felt, binder's board, and gutta-percha. Of these, sole leather is by far the least objectionable in most cases, as it can be adapted easily, is firm, clean, and agreeable to the patient, and does not confine the exhalations. The same splint can be used for an indefinite number of cases by again making it pliable with water. For other fractures of the leg, such as the compound, and those with serious complications, the fracture box, with its modifications, is ordinarily used. For the leather splints, besides the above-named merits, it is claimed that they are as efficient in preserving the coaptation of the fractured bones as any other dressing, that a requisite amount of extension may be maintained when required, and that the patient is not compelled to keep his bed, but may get up, and with his crutches go about and attend to his business. But, the more fully to appreciate its worth, let us compare it with other dressings which are in use in the hospital. Pott's splint, or its counterpart the

double inclined plane, has for its object the reduction of the anterior displacement of the upper fragment of the tibia, by the relaxation of the posterior muscles; but what surgeon does not know that he is too often baffled in his efforts to effect a reduction of the bones by this postural method? For what is gained by relaxing the muscles which act upon the lower fragment, is often lost by the tension of the quadriceps extensor muscles upon the upper fragment, through the ligamentum patellæ. Moreover, the employment of this apparatus obliges the patient to remain in bed. Now this displacement of the fragments of the tibia can be much more satisfactorily corrected by simple extension than in any other way; and that dressing which will subserve this purpose with the least inconvenience to the patient and surgeon, is the one which should be preferred. This we claim for the leather splint, by cutting out of firm sole leather two pieces, which can, when wetted, be neatly adjusted to the foot and leg so as nearly to surround the limb, and with a roller firmly securing the foot pieces to the foot. Giving the foot thus bandaged to an assistant, who makes the desired amount of extension, the surgeon continues the roller firmly upwards till the knee is reached. The mechanism of the extension thus obtained can best be expressed by supposing the leg to represent a truncated cone, with its base upwards, and corresponding to the greatest diameter of the leg; now by confining the splints to the foot, which is acted upon as a *point d'appui*, we next ensheathe the conical limb above in a firm mould, and it is easy to conceive how difficult it would be for any given segment of this graduated cone to approximate the foot, even though the natural support afforded by the bones be absent, as in oblique fractures; for this could not occur without forcibly wedging the cone with an increasing circumference above into the mould, with a decreasing circumference below. In short, the unyielding leather, supported by the roller, is the extension, and the conical shape of the limb the counter extension. This explanation of the manner of extension is pleasing in theory, and the results obtained in practice demonstrate its correctness. These splints, when applied, not only allow the patient a greater degree of mobility and comfort in bed than either Pott's splint or the inclined plane, but also allow him to leave his bed and go about. Thus we have the indications answered with less inconvenience to the patient than when treated on the postural plan. It may be objected that a considerable portion of the tibia extends above the base of this cone, and in consequence extension cannot be made at the upper part of the bone; and further, that the prominences about the foot will not endure as much pressure as is presupposed. To these the answer is, first, that most fractures which require extension are those which override from the obliquity of the fracture, and such are almost always situated below the greatest circumference of the leg, those above this point being transverse, or so nearly so as to occasion but little displacement; and all that is required in these cases are splints of coaptation, which the leg-pieces of the leather readily furnish. If, however, it be found necessary to make extension, the prominence at the head of the tibia will be found a sufficient means for counter-extension. The second objection is disposed of by padding the leather with cotton-wool over all the prominent portions of the foot.

(To be Continued.)

THE BINOCULAR MICROSCOPE.—The binocular microscope is fast growing into favor with the microscopists of New York and the vicinity, it being pretty generally conceded that it is much superior to the ordinary single-tubed instrument. The stereoscopic effect which it is enabled to produce is truly wonderful, even with high powers. We have seen with one of Mr. Grunow's instruments the human blood-globules having that degree of projection as to appear actually tangible. The edges were rounded out to that extent that we could almost see behind them. }

Reports of Societies.

NEW YORK ACADEMY OF MEDICINE.

STATED MEETING, May 18, 1864.

DR. JAMES ANDERSON, PRESIDENT, IN THE CHAIR.

DR. NOYES exhibited a specimen of the Calabar bean, and referred to its botanical and therapeutical properties.

CANCER OF THE RECTUM.

DR. PARKER opened the discussion on cancer of the rectum. The substance of his remarks may be summed up as follows: The most frequent seat of cancer of the rectum is about one and a half inches from the sphincter, and usually gives rise to stricture of the gut at that point. The symptoms at first are exceedingly vague, there being generally only a slight sense of uneasiness about the anus, with twinging pains and some aching about the sacrum. As the disease progresses, there is an involuntary discharge of mucus from the anus, with impairment of the general health. The diagnosis is easy if the stricture can be reached with the finger. Sometimes bougies are used to detect the existence of the stricture when high up. The finger is always the best instrument if it can reach far enough.

The best position to place the patient in for examination is either lying upon the side, with thighs firmly drawn up against abdomen, or squatting upon, and over the edge of a chair. The treatment principally consists in the use of palliative measures. If the gut is occluded, the deposit may be broken down by the finger; if partially closed, injections may serve to liquefy the faeces above and give an easy passage. Sometimes it is necessary to nick the edges of the stricture, and afterwards resort to *gradual* and *careful* dilatation with a bougie. Active or forcible dilatation is always bad, as it may cause a rupture of the gut and peritonitis. Amusat's modification of Calisen's operation is sometimes resorted to.

DR. POST referred to a case of cancer of the rectum, in which there was entire occlusion of the gut for twenty-nine days. He had seen but one such case. In most instances nature liquefied the faeces, and a diarrhoea often alleviated the distressing symptoms. He had known of some cases where the disease had existed for a long time, and caused a large deposit in the intestine without occasioning any inconvenience.

FISTULA IN ANO.

DR. POST then proceeded to offer a few remarks on the subject of fistula in ano. He divided fistulae into three classes—1. Complete; 2. Incomplete external; and 3. Incomplete internal. He believed that in very many of the cases that were supposed to be of the incomplete external variety, an internal opening could be found, if the probe was made to search for it lower down than is usually done. He advocated the use of a probe provided with a handle, as the instrument by that means was prevented from twisting itself as it followed the tortuosities of the fistulous tract. In most of the instances, he had found the internal opening of the fistula so near the anus, that the point of the knife could be made to pass through it out of the anus; the parts could then be divided by a cutting process, and this is by far less painful than the ordinary method.

DR. PARKER asked if the ligature had been often used by the members for the treatment of such cases.

DR. PEASLEE stated that he had made use of the ligature in probably ten cases, but on account of the tediousness of the cure, and the want of that uniform success which some claimed for it, he had abandoned it for the knife.

DR. UNDERHILL had seen the ligature tried, but with no good effect. He much preferred the knife.

DR. PARKER uses the ligature in cases where the fistula is superficial, but prefers the knife for those that are deeply seated.

DR. HUTCHINSON favored the use of the ligature, even when there was a very considerable amount of tissue to cut through. He advocated its employment, especially in cases where there was a tuberculous diathesis present, and where it was necessary that the cure should be a gradual one.

DR. FOSTER referred to the case of a medical man who was cured by the ligature without the loss of an hour's time. There was no pain or inconvenience attendant upon the treatment.

DR. GARRISH preferred the knife for the superficial fistula, but relied upon the ligature when considerable tissue had to be divided, because he thought that hæmorrhage by that means could be prevented.

DR. BATCHELDER recommended the use of the spongent in the treatment of stricture of the rectum.

DR. FOSTER offered some resolutions concerning the death of DR. M. E. WINCHELL, after which the Academy adjourned.

NEW YORK PATHOLOGICAL SOCIETY.

STATED MEETING, January 13, 1864.

DR. D. S. CONANT, PRESIDENT, IN THE CHAIR.

ANEURISM OF THE ASCENDING AORTA, ETC., ETC.

DR. FLINT presented three specimens. The first consisted of an aneurism of the ascending aorta, insufficiency of the aortic valves, with hypertrophy, and dilatation of the left ventricle. The cavity of the aneurism contained no fibrine, but abundance of calcified plates. The patient was admitted into Bellevue Hospital two months ago, and while there was attacked with typhus, and died. The diagnosis of the cardiac trouble was readily made out.

AORTIC ANEURISM AND ANEURISM OF THE LEFT CORONARY ARTERY.

The second specimen was one of commencing aortic aneurism, but inasmuch as the patient died suddenly shortly after admission into the hospital, no history of his case could be ascertained. The left ventricle was hypertrophied and dilated, the dilatation predominating over the hypertrophy. There was considerable dilatation of the aorta, and also a rather abundant deposit of calcareous matter. Some aortic insufficiency was also noticed, but the point of interest in the specimen was the existence in the left auricle of a calcareous tumor, the size of a hickory nut, on the projecting part of which the endocardium was removed. The interior of this tumor contained coagula, which belonged to an aneurism of the left coronary artery.

The case, as far as this latter condition of things was concerned, was to Dr. Flint a unique one. The calcareous degeneration prevented a rupture of the aneurism, but an interesting question presents itself—What would have been the ultimate result had the walls of the sac given way, and thus virtually opened a communication between the affected artery and the cavity of the left ventricle? The substance of the heart would certainly have been deprived of part of its supply of blood.

DISEASE OF THE AORTIC AND MITRAL VALVES.—MITRAL DIRECT MURMUR.

DR. FLINT presented the third specimen, in order to place upon record some remarks with regard to the mitral direct murmur.

The heart was taken from a patient, a female, æt. 40, who died at Bellevue, having been under observation for three years. She had three murmurs, the aortic direct and regurgitant, and the *mitral direct*.

Concerning the very existence of the mitral direct murmur, Dr. Flint remarked that there had been a considerable amount of discussion in this city, but he wished to present this as a case in point, and one which a great number of medical men, together with his private classes, had had an opportunity of seeing. He was strongly inclined to think that the direct murmur was often confounded with the

mitral regurgitation, inasmuch as he was satisfied that the former was not so rare as those who believed in its existence were in the habit of supposing it to be. The distinctive points connected with this murmur are, that in the first place it immediately precedes the systole, and is instantly arrested on the contraction of the ventricle—in other words, it is pre-systolic; secondly, there is a distinct interval between the ending of the second sound and the commencement of the murmur. The murmur is usually a rough one. Dr. Flint was aware that he had stated the contrary to be the case in his book, but a more extensive experience with the murmur enabled him to correct the error there made. It has a peculiar vibratory, or "blurring" character, the sound much resembling that produced by throwing the lips and tongue in vibration. The conditions which are necessary for its production are obstruction of the mitral orifice and flaccidity of the mitral curtains. In this specimen the mitral orifice is contracted to the "button-hole slit." The auricle, contracting just before the ventricle propels the blood through this contracted orifice, throws the valve into vibration just previous to the systole. This murmur may exist without organic disease of the mitral valve, simply as the result of insufficiency of the aortic valves. As the result of the regurgitation, we have the ventricle, immediately after contraction, sufficiently filled with blood to float up the mitral valve far enough to be thrown into vibration by the auriculo-ventricular current.

In connexion with Dr. Flint's second specimen, Dr. Post remarked that there was a specimen of coronary aneurism in the Museum of the New York Hospital; he did not, however, recollect as to whether its walls were composed of calcareous matter.

Dr. SANDS referred to a case of mitral direct murmur, which he had met with while an interne in Bellevue Hospital. The relation of the murmur to the first sound could clearly be made out.

In answer to questions from Drs. Bibbins and Jacobi, Dr. FLINT made some explanatory remarks concerning the general characters of the mitral direct murmur.

(To be Continued.)

American Medical Times.

SATURDAY, JUNE 4, 1864.

MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

THE assembling of the AMERICAN MEDICAL ASSOCIATION in this city during the ensuing week must prove one of the most interesting as well as important events in the current history of the profession. Though feeble in its beginning, and exercising only very limited control over the great mass of medical men, the Association gradually grew in power and influence, until, at the commencement of the Rebellion, it had achieved a position little if any inferior to that of a legislative body. Its decisions on all matters pertaining to the ethics of the profession, to medical education, to the character of the schools, etc., were received as final, and respected as authority. It had, in fact, become, as its friends were proud to designate it, the National Medical Congress. The Association was the only voluntary national organization at the outbreak of the war which remained in all its integrity, in spite of the growing sectional feeling which had violently thwarted all other efforts at national brotherhood. We are not aware that the medical profession of the Southern States have entertained other than the kindest feelings towards this great central organization; and its power must be considered, therefore,

as simply suspended, as were its annual meetings, by our civil dissensions.

Every medical man, solicitous for the honor, dignity, and progress of his profession, seems cordially to welcome the return of the annual meetings of this Association. Like the French and English national associations, it gives compactness and uniformity to the great mass of medical minds, and concentrates their sympathies and efforts on all reforms and improvements. But the American Medical Association serves a still higher and nobler purpose than other similar societies. It is our Court of Appeal in all questions relating to medical ethics, the status of schools, individuals, voluntary organizations, etc., etc. Such an organization is eminently necessary to preserve the integrity and harmony of the profession. England has its Medical Council, which under the statute legislates with the power of a corporate body, and this is in accordance with her institutions. But the nearest approach to such a medical governing body we can attempt, is a voluntary organization which carries sufficient inherent moral force to render its decrees binding. Such is the position attained by the American Medical Association, and such is the character with which every one should strive to clothe it; to this end we must foster its growth, and the extension of its influence. Every question affecting the great body of the profession, and every cause of dissension that cannot be settled by local societies without creating discord, should be referred to this body, and its decisions should not only be respected but faithfully followed. Thus the Association will truly become a great National Medical Congress in which every interest is represented, and whose annual legislation will elevate, purify, and strengthen the profession, and bind more closely the bonds of fellowship.

The division of labor by the organization of sections was dispensed with at the last meeting. At the previous meeting at New Haven these sections had been found to work well, giving larger scope and more thoroughness to the discussions. There can be no doubt that if properly managed the sections will be found an essential part of the scientific proceedings of the Association. They admit of the reading of papers which would otherwise be noticed only by their titles, and give ample opportunity for the consideration of the practical or theoretical questions which are presented.

The necessity of a permanent Secretary becomes more and more evident as the business of the Association accumulates. Under the present system it is quite impossible to secure the despatch that is required. The important duties of the Secretaryship, resting upon two persons widely separated, and frequently not acting in harmony, can never be faithfully discharged. The whole responsibility of this office should be placed upon a single person, and he should be held rigidly accountable for the prompt and correct fulfilment of his obligations. The office should be permanent, or at least should continue for a number of years, in order to render the Secretary entirely familiar with the business matters of the Association. The brief term of a year does not permit of any preparation, and whatever qualifications the Secretary may have, natural or acquired, they do not seem to render him a capable officer at once. As this office, well discharged, can be no sinecure, the permanent Secretary should be liberally paid. The Association is now able to give a high character to its permanent officers, and in no way can it do so more advantageously and justly than

by placing its Secretary upon a firm financial basis. If it is decided at the present meeting to establish a permanent Secretaryship, we trust the Association will exercise more than ordinary care and discretion in the selection of this officer. He should be a man of elevated character and reputation in the profession, of great business habits, sincerely devoted to the interests and welfare of the profession, and resident at some accessible point. No mere parvenu should be allowed to attain to an office of so much importance to the future success of the Association. Men of high position can be found who will fill the situation with dignity and with honor.

An effort was made at the last meeting to secure the adoption of a rule prohibiting the selection of a president from the locality where the session of the Association is held. We are not aware of the considerations which prompted the advocates of this proposition, and can treat the question only in its abstract sense. In every view that we can take of it such a rule is uncalled for, and would be both unjust and unwise. It is uncalled for, because there has not been a settled policy on the part of the Association to select its President from the locality where the sessions are held. At meetings previously held in New York and elsewhere, the President has been chosen from other localities. In the instance of the session in this city, the claims of several of the most eminent members of the profession, resident in New York, were disregarded, and Prof. KNIGHT, of New Haven, was elected. Such a rule will frequently operate very unjustly by preventing worthy men from enjoying the honors of the Association. The position of President is no mean distinction, and there are few who do not esteem it worthy of the highest ambition. Finally, any such limitation of the Association in the selection of its officers would be unwise and impolitic. This body should be entirely free, as should every voluntary organization, in the selection of a presiding officer.

Many subjects of great general interest to the profession, as medical education, examining boards, specialism, etc. etc., will be brought forward for discussion and adjudication. Subjects also of more immediate interest to the army medical service will probably be introduced, and the opinion of the Association will be solicited. It is not our province to discuss these questions in advance, but we may state that they should all receive full and impartial consideration. The Association should pass no matter by unnoticed, or slighted, which has been respectfully referred to it for a decision. Nor should its decisions be hastily given without due discussion and investigation. If its conclusions are to be respected they must be based upon an impartial as well as thorough and exhaustive examination. Most questions should be referred to committees to report at a subsequent meeting, thus giving ample time for investigation.

In behalf of the profession of New York we most cordially welcome the delegates and members of the Association to this city. As it was here that the first steps were taken in its organization, and that its largest and most enthusiastic meetings have been held, it is eminently proper that New York should give the Association renewed life after a season of suspended animation. Every needful effort has been made by the profession of this city to render the session pleasant and profitable, and we anticipate being called upon to chronicle the proceedings of one of the most successful meetings of this body ever held.

THE TRANSFER OF THE SEVERELY WOUNDED.

WE are glad to learn that the severely wounded are to be transferred to the hospitals throughout the North and East, and have no doubt but that the move will be attended with great benefit. It has heretofore been the practice of sending North crowds of incorrigible malingerers, who manage by well contrived artifices to be on the sick list for months at a time. The fact is, this class of individuals are determined *never* to get well of their various pains and aches so long as they can be near enough to their homes to get to them on passes, or to receive visits of sympathizing relatives and friends, or occasionally to rusticate on a furlough. It is on account of such inmates as these that the General Hospitals of the North have acquired the unenviable reputation of demoralizing the army by affording places of refuge for so large a class of cowards. This could all be remedied by keeping such patients as near to their commands as possible, and have their places in our wards supplied by men who, by virtue of their honorable wounds or severe indispositions, are entitled to all the advantages which a Northern climate can confer. To such deserving ones the proximity of their friends acts beneficially and tends greatly towards a rapid recovery. They are either too sick or too badly wounded to be constantly asking for furloughs, and are content patiently and quietly to submit to treatment. If we have our hospitals well filled with such as these, we can answer for it that the lumbagoes, rheumatic attacks, and side-aches can be as well, and a great deal better, treated further from home. As an example of the beneficial effects of climate upon disease, we need only instance that of chronic diarrhoea, which, as is well known, sometimes only requires northern air to establish a cure. We see no reason, either, why wounds should not heal quicker under the same influences. In properly constructed vessels, the transportation to New York and the vicinity is easy, and we understand that such transports are being rapidly fitted out, each supplied with a competent surgeon-in-charge. We are exceedingly anxious to see the experiment tried, as we are confident of its success. There are a number of hospitals throughout the Department of the East, which, by their location and surroundings, are peculiarly adapted for the reception of such severe cases as may be sent.

OUR CONTENTS.

WE have no doubt but that our readers will be edified by the perusal of the lecture by DR. PARKER in our present number, as also of the report of PROF. NOEGGERATH's Clinic. We are happy to state that both these gentlemen intend in future to contribute more or less regularly to our columns. The remaining portion of the journal also contains interesting articles, each of which will show its special claims to attention after having been read.

THE PAY OF ACTING ASSISTANT-SURGEONS.

ON account of the present depreciation in paper currency, the pay of our Surgeons is necessarily narrowed down to quite a small figure, and the Acting Assistant Surgeons, who, as far as remuneration is concerned, are at the bottom of the list, necessarily suffer the most. This being the case, we can easily understand why the demand for this class of medical laborers is still urgent. Until the Government chooses to increase the pay, it cannot expect to have its wants supplied. No respectable practitioner can, for

simply a hundred dollars a month, be tempted to leave his business for any length of time, even for temporary service; and the hospitals of the country will necessarily soon get filled with young irresponsible medical striplings. If the Government wishes first-class men it must pay first-class prices.

NEXT PRESIDENT OF THE ASSOCIATION.

THERE is already an active canvass of the claims of members for this high position. A number of names have been suggested, and each has its special and earnest advocates. But there is one name which transcends all others, and to which we must accord the most profound respect. It is the name of MOTT. He whose life is contemporaneous with American surgery, and whose genius has done so much to advance it and give it an exalted position among foreign nationalities, still lives among us, hale and hearty, and as much alive to the interests of the profession as when he commenced his career, half a century ago. His name cannot be rendered more illustrious or his fame more enduring by any honors which we may bestow; but we believe the Association might well be proud hereafter to point to the name of MOTT among her Presidents.

Reviews.

TRANSACTIONS OF THE ILLINOIS STATE MEDICAL SOCIETY, FOR THE YEARS 1861, '62, AND '63.

THE eleventh annual meeting of this Society was held in Jacksonville, May 5th, 1863. The first paper is a Report on Typhoid Fever, by H. NOBLE, M.D., of Heyworth. His opinion is, that the disease is located especially in the mucous coat of the intestines, but not necessarily associated with ulceration of Peyer's glands, or any other tissue. In the fatal cases he has seen death result from perforation of the intestine, exhaustion of the vital forces, or from the complication of other diseases. He does not believe in *curing*, as some do, in from four to six days, but directs his treatment first, to the correction of the supposed lesion of the intestines, and next to sustaining the patient. After evacuating the bowels with a mercurial, combined with from one to three grains of quinine, he gives nitric acid, diluted to about the strength of good vinegar, in teaspoonful doses, repeated in four or six hours. Should the tongue become red and shining, the natural color is restored by the use of turpentine, in doses of from twenty to sixty drops, from two to four times a day, when the acid is resumed, and continued until convalescence is established. If the secretions become deranged, they are restored by calomel.—*Report of the Special Committee on Diseases of the Eye*, by E. L. HOLMES, M.D., of Chicago, is an account of some of the diseases coming immediately under the notice of the Committee, no communication having been received from any member of the Society.—*Minor Mental Maladies*, by ANDREW MCFARLAND, M.D., embraces some account of those numerous vagaries we meet with, whether social, political, or religious; and while "Moral Insanity," as a plea to screen villainy, is denounced, the author believes that the physician too often overlooks an incipient mental malady, which would mitigate some minor offence for which the accused suffers punishment.—*Report of the Committee on Surgery*, by PROF. E. ANDREWS, of Chicago, recounts some of the recent improvements made in civil surgery, especially in the treatment of fractures, and gives some account of the military practice seen by a portion of the Committee.—*Delayed Union of Fractures, with Cases and Illustrations*, by DAVID PRINCE, M.D., is a brief resumé of the different methods of treating this accident; with a

history of a case successfully treated by drilling, followed by compression of the fragments by means of Malgaigne's spike, drilling employed by itself having proved unsuccessful.

Correspondence.

FREDERICKSBURGH.

Special Correspondence.

By direction of SURGEON-GENERAL QUACKENBUSH of the State of New York, the following surgeons of New York City reported on the 10th inst. to SURGEON-GENERAL BARNES, at Washington, for duty at Fredericksburgh, Va., viz. DRS. GURDON BUCK, WM. DETMOLD, H. B. SANDS, STEPHEN SMITH, FRANK H. HAMILTON, and T. C. FINNELL. From Washington to Belle Plain they were accompanied by COL. CUYLER, Act. Med. Inspector-General, who visited the latter place to facilitate the transfer of the wounded. The wounded had just begun to arrive at this point, and as there was neither house nor wharf, it required all the efforts of this energetic officer to introduce any system into the chaos that reigned on his arrival. All the soldiers who reached this point were but slightly wounded, and most of them had walked from Fredericksburgh, about ten miles distant. Belle Plain is but a landing at the mouth of Potomac Creek, without a house or sign of habitation. The Sanitary and Christian Commissions had preceded us, though we were but a few hours later than the first boat that reached the place, and had established their kitchens and were busy feeding the weary and exhausted multitudes which constantly streamed over the hills. A ride of four hours over a most disagreeable road brought us to Fredericksburgh at six o'clock P.M. of the 12th inst., where we reported to SURGEON E. B. DALTON, Medical Director.

There were at that time not far from four thousand wounded in the city, scattered throughout all the available buildings, as churches, hotels, stores, warehouses, etc., etc. On first entering these suddenly extemporized hospitals, we were struck with the utter destitution of all medical and hospital supplies. The patients lay thickly upon the floors, with only their dirty, tattered, blood, and pus-besmeared garments under and around them, and neither bandage, lint, nor old linen could be obtained to dress their offensive wounds. There was also great destitution of food, especially such as the severely wounded require. There can, however, be no blame attached to the Medical Department for this absence of hospital supplies. It was the design of the military authorities to gather the wounded at Rappahannock Station, and transport them by railroad to Washington, but the first train was intercepted by the rebels, and compelled to turn back. It was only after repeated attempts to reach a railroad station that it was decided to go directly to Fredericksburgh, which was then picketed by the rebels. This town had been stripped of everything available for the sick by the rebels, and the nearest point at which supplies could approach it by water was Belle Plain. To notify the authorities at Washington that Fredericksburgh was to be the dépôt for the wounded, to ship and unship supplies to Belle Plain, and to transport them over a most difficult road, necessarily required time. Every effort was, however, being put forth by the Surgeon-General to forward rapidly the requisite material. It should be added, also, that as soon as the Fredericksburgh road was opened it was occupied, as was the wharf at Belle Plain, by the ordnance trains of the army, to the exclusion for two days of the medical train.

The Sanitary Commission, however, with that lightness and fleetness which characterize all its movements, pressed through three wagon loads on the second day, and almost immediately began to distribute the precious gifts to the suffering. On the following days its supplies came in in greater abundance, and relieved the immediate wants. It

was interesting to notice the affection of the soldiers for this great charity. It was a common remark among the wounded, "If the Old Sanitary is around we shan't suffer."

The Christian Commission was also early on the ground, and furnished a large variety of indispensable articles. Its agents visited the hospitals with pitchers of milk-punch, which was very grateful to the severely wounded.

Whatever may be said against these organizations, they are truly worthy of the earnest support of the people. They furnish aid that does not come within the duties of the Medical Department, and they were certainly on this occasion earlier on the ground than the latter.

MAY 15, 1864.

Army and Navy Intelligence.

CIRCULAR LETTER.

SURGEON-GENERAL'S OFFICE,
WASHINGTON, D.C., May 26, 1864.

The following Order from the War Department is respectfully furnished for your information and guidance:

WAR DEPARTMENT,
WASHINGTON, D.C., May 20, 1864.

Accounts for newspaper advertising for the Bureaux of the War Department must be rendered in duplicate, and state upon their face—

- The name of the publisher or firm;
- The name of the newspaper, and the place where published;
- The dates between which inserted;
- The amount of matter and number of insertions charged for, and rate per square or line; and must be accompanied by a full schedule of the customary advertising terms of the newspaper, unless the same shall have been previously filed with the Assistant Secretary of War.

Accounts must then be verified by the officer by whom the advertisements are signed, stating that the publication was authorized by him, and the number of insertions ordered.

Advertisements copied from other papers, *without authority*, will not be paid for.

The attention of officers is directed to the fact that the practice of ordering advertisements to be inserted "till day" of sale, etc., involves a useless expenditure, in cases where the station of the officer is remote from the place of publication.

Officers issuing advertisements for publication will, at the same time, transmit copies of the same to the Assistant Secretary of War, stating the newspapers in which they are to be published, and the number of insertions ordered; and whenever only a portion of the official newspapers in any locality are selected to publish any advertisement, the officer will state his reasons for selecting the particular papers in question, and also his reasons for not advertising in the other official papers in that locality.

- a. By order of the Acting Surgeon-General:
(Signed) C. A. DANA,
Assistant Secretary of War.
- By Order of the Secretary of War:
C. H. CRANE,
Surgeon, U.S.A.

(GENERAL ORDERS, No. 198.)

WAR DEPARTMENT, ADJUTANT-GENERAL'S OFFICE,
WASHINGTON, D.C., May 12, 1864.

Duties of Assistant Surgeon-General:

To facilitate the prompt transmission of medical supplies to points developed by emergencies, secure the proper distribution and presence of medical officers and their assistants where their services are most required, and to provide comfortable, abundant, and available hospital accommodation for the sick and wounded of the Armies of the West and South-west, the office of the Assistant Surgeon-General is established at Louisville, Ky.

To fully accomplish these important objects, Assistant Surgeon-General R. C. Wood will have immediate control, under the general direction of the Surgeon-General, of the Medical affairs in the Military Department of the North-west, the Northern Department, the Department of Kansas, Missouri, and those composing the Division of the Mississippi, except that officers assigned to duty with any Army or Department will not be removed therefrom, unless by order of the War Department.

The orders, circulars, and instructions heretofore published by the Assistant Surgeon-General, and such as may in future be required, will be obeyed and respected by all under his jurisdiction.

By Order of the Secretary of War:

E. D. TOWNSEND,
Assistant Adjutant-General.

Official:

ORDERS, CHANGES, &c.

MISCELLANEOUS.

Surgeon R. D. Lynde, U.S.V., has been ordered to Washington as a witness before a military commission.

Surgeon A. M. Clark, U.S.V., has reported for duty to General Butler, at Bermuda Landing.

Surgeon N. K. Derby, U.S.V., was wounded at the battle of Cane River, while Medical Director to the Red River expedition.

The Fort Schuyler General Hospital, at New York, and the General Hospital, at Chester, Pa., have been re-transferred to the Medical Department.

Surgeon J. J. De Lamater, U.S.V., has reported for duty at Fort Monroe, Va.

Surgeon R. Nicolls, U.S.V., has reported for duty to Assistant Surgeon-General Wood, at Louisville, Ky.

Surgeon C. F. H. Campbell, U.S.V., is sick at his home in Philadelphia, Pa.

The U. S. Barracks at Augusta, Me., have been turned over to the Medical Department for a hospital.

A hospital of the capacity of five hundred beds is being fitted up at Montpelier, Vt.

Surgeon G. H. Hubbard, U.S.V., has been ordered to resume his duties as Medical Director, District of the Frontier, Fort Smith, Ark.

The Barracks at Willett's Point, N. Y., those recently occupied by the 1st D. C. Cavalry, at Washington, D.C., and the District of Columbia Armory, have been turned over to the Surgeon-General for hospital purposes.

The Board of Inspectors, instituted in Special Orders 514, series of 1863, from the War Department, to inspect the Government Hospitals and Military Prisons in the Department of Washington, has been dissolved.

The General Hospital at Willett's Point, N. Y., will be known as the Grant Hospital.

Surgeon J. G. Keenon, U.S.A., has resumed charge of the Adams Hospital, Memphis, Tenn.

ORDERS.

Surgeon A. H. Thurston, U.S.V., is relieved from duty in the Army of the Potomac, and will report to the Commanding General, Department of Washington.

Surgeon G. H. Hubbard, U.S.V., is relieved from duty in the Department of Arkansas, and will report to the Commanding General, Department of the East.

Surgeon J. Leavens, U.S.V., is relieved from duty in the Department of the East, and will report to the Commanding General, Department of Washington.

Surgeon Gideon S. Palmer, U.S.V., is relieved from duty in the Department of the Cumberland, and will report to Surgeon Josiah Simpson, U.S.A., Medical Director, Middle Department, to assume the duties lately performed by Surgeon Charles Sutherland, U.S.A., at Annapolis, Md.

Hospital Chaplain C. W. Heisly, U.S.A., will report to the Commanding General, Department of the South, to relieve Hospital Chaplain J. White, U.S.A.

Surgeon C. Sutherland, U.S.A., is relieved from duty at Annapolis, Md., and will report in person to the Surgeon-General for assignment to duty.

Surgeon Charles Sutherland, U.S.A., is assigned to duty as Medical Purveyor at Washington, D.C., to relieve Medical Storekeeper H. Johnson, U.S.A. On being relieved Medical Storekeeper Johnson will report to Surgeon Sutherland for duty.

Surgeon J. H. Peabody, U.S.V., is relieved from duty in the Department of the Missouri, and will report to the Commanding General, Department of Kansas.

Surgeon C. F. H. Campbell, U.S.V., is relieved from duty in the Department of Missouri, and will report to the Commanding General, Middle Department.

DISCHARGES, DISMISSALS, ETC.

Assistant-Surgeon N. S. Drake, 16th New York Cavalry, dismissed by sentence General Court-Martial for conduct unbecoming an officer, General Orders No. 31, Headquarters Department of Washington.

Hospital Steward John A. Seaton, U.S.A., honorably discharged.

Medical Cadet Francis P. Casey, U.S.A., honorably discharged to enable him to accept the appointment of Assistant-Surgeon, 8th New York Artillery.

Surgeon E. M. Seely, 21st Illinois Vols., honorably discharged, having tendered his resignation on account of physical disability.

Private C. C. Eia, Co. "G," 10th Maine Vols., honorably discharged to enable him to accept an appointment as Acting Assistant-Surgeon U.S.A.

Assistant-Surgeon James L. Chipman, 39th Massachusetts Vols., honorably discharged on account of physical disability, on recommendation of a Board of Officers.

Assistant-Surgeon James A. Emmerton, 23d Massachusetts Vols., and Samuel C. Whitier, 11th Massachusetts Vols., honorably discharged at the request of the Governor of Massachusetts, to enable them to accept commissions in other regiments.

RESIGNED.

Hospital Chaplain Henry Hopkins, U.S.A., to take effect May 25, 1864.

LEAVE OF ABSENCE.

Hospital Chaplain James White, U.S.A., for sixty days for the benefit of his health.

Surgeons Daniel Meeker and Charles J. Kip, U.S.V., for ten days each.

APPOINTED.

Assistant-Surgeon Lyman Allen to be Surgeon 5th Regiment U. S. Colored Troops.

Dr. William A. Spears to be Assistant-Surgeon 1st Regiment Michigan Colored Volunteers.

Charles Haslam, Robert J. Strong, W. B. Young, and T. D. Smith, U.S.V., and Henry C. Saxton, of Washington, to be Hospital Stewards U.S.A.

DIED.—Assistant-Surgeon John T. Riley, U.S.A., on the 5th of May, 1864, at Helena, Ark., while en route from Little Rock, Ark., to Louisville, Ky., after a few hours' illness.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 16th day of May to the 23d day of May, 1864.

Deaths.—Men, 121; women, 88; boys, 110; girls, 95. Children born of native parents, 54; foreign, 164; not stated, 7; total, 414. Adults, 269; children, 293; males, 231; females, 183; colored persons, 11.

Among the causes of death we notice:—Erysipelas, 9; albuminuria, 9; apoplexy, 6; infantile convulsions, 21; croup, 9; diphtheria, 24; scarlet fever, 18; puerperal fever, 9; typhus and typhoid fevers, 23; consumption, 65; small-pox, 6; measles, 3; dropsy in head, 17; infantile marasmus, 12; whooping-cough, 2; inflammation of brain, 9; of bowels, 9; of lungs, 23; bronchitis, 6; diarrhoea and dysentery, 18. 200 deaths occurred from acute diseases, and 35 from violent causes. 272 were native, and 142 foreign; of whom 89 came from Ireland; 73 died in the City Charities, of whom 9 were in Bellevue Hospital, and 13 died in the Immigrant Institution.

Abstract of the Atmospheric Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

May 1864.		SIX A.M.				TWO P.M.				TEN P.M.				
		°	Minimum Temperature.	Evaporation Below.	Barometer.	Wind.	°	Minimum Temperature.	Evap. Below.	Barometer.	Wind.	°	Minimum Temperature.	Evap. Below.
15th.	47.48	%	29.99	N.E.	57	1	29.99	N.E.	58	0	29.90	N.E.		
16th.	50.50	%	29.99	Fog.	58	1%	29.99	S.E.	58	2	29.96	N.E.		
17th.	54.56	1	29.84	Fog.	71	3	29.81	S.E.	58	3	29.77	S.E.		
18th.	60.62	2%	29.76	S.W.	72	4	29.77	S.E.	60	3	29.76	S.E.		
19th.	60.60	2	29.81	Fog.	73	6	29.83	S.E.	61	3	29.83	S.E.		
20th.	54.54	3	29.84	Fog.	74	7	29.82	S.W.	64	4	29.81	S.W.		
21st.	68.64	2	29.76	S.W.	81	7	29.64	S.W.	71	3	29.71	S.W.		

REMARKS.—15th. Hard showers early; showery day. 16th. Cloudy; light showers middle of the day. 17th. Variable. 18th. Cloudy early; day mostly obscured. 19th. Variable. 20th. Mostly clear. 21st. Mostly clear; sultry; cloudy night. Rain for the last two weeks one and three-quarter inches.

SPECIAL NOTICE.

AMERICAN MEDICAL ASSOCIATION.—*Delegates residing in this City or Brooklyn, and those who may be here, are requested to call at Irving Hall, to present their credentials and register their names, etc., on Monday afternoon, June 6, between 12 and 5 o'clock.*

NEW YORK COUNTY MEDICAL SOCIETY.—*A Stated Meeting of the above Society will be held at the College of Physicians and Surgeons, corner of 23d street and 4th Avenue, on Monday Evening next, June 6, at 8 o'clock. DR. JONAS P. LOINES will read a Paper on Vaccination, and present cases to the Society illustrating the development and maturation of the vaccine vesicle. After which the treatment of Membranous Croup by Hot Vapor will be discussed.*

The Profession is respectfully invited to attend.

AMERICAN MEDICAL ASSOCIATION

Will meet at the IRVING HALL, corner of Irving Place and 15th Street.

That the organization of the meeting may be effected with as little delay as possible, and at the appointed hour of 10 A.M., the Committee of Arrangements particularly request that the secretaries of the several bodies purposing to send delegates to the Association, would forward their appointments immediately upon their being made. This will be voucher for the delegate, and will avoid every embarrassment in registration. The delegate may present his voucher from the Secretary. Delegates desiring to read "papers, essays, or memoirs" will send early the title and time required to read them. The Committee will be in session on Monday, 6th from 12 o'clock to 5 P.M., and Tuesday morning at 8, in the Irving Hall, in Irving Place.

The Medical Periodicals are requested to publish the above, and keep it before the profession until the time of meeting.

JAMES ANDERSON, Chairman,
80 University Place

Dr. Frank H. Hamilton has removed
his office and residence to 64 Madison Avenue.

Wm. Frothingham, M.D., late House
Surgeon and Physician, Bellevue Hospital, cor. 138th st. and 10th Avenue, Washington Heights, New York.

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715 and 717 Market St., Philad.

VACCINE

Virus of all kinds, perfectly pure, and

most reliable, used by the leading physicians of this city; put up in the best form for transmission to any part of the world. Prices—single tube, 75 cts.; three, \$2; single charge of eighth-day lymph, on pointed quills, 15 cts.; fifteen points, \$1; single charge, on convex surface of section of quill, 20 cts.; ten, \$1. Crusts from \$1 to \$1.50, according to weight.

A new stock of vaccine on hand, May 17th; two removes from the cow.

Address,

J. P. LOINES, M.D.,
Eastern Dispensary, 57 Essex Street, New York.

The "Fifth Avenue Pharmacy,"

No. 157 FIFTH AVE. (BET. 21ST AND 22D STS.),

NEW YORK.

JOHN CANAVAN, Pharmacist.

Dr. Munde's Water-Cure Establish-

MENT AT FLORENCE, MASS. (near Northampton), is pleasantly situated in a healthy mountain region, amply supplied with the purest, softest, and coldest granite water. Shady walks and drives, with pleasant views all around; bowling alleys; boats; billiard table; pianos; gymnastics; several hundred feet of covered piazzas; rooms all light and airy; diet plain, but nourishing, abundant and well prepared; the whole of the Institute managed with care, order, and neatness. Dr. Munde, though the oldest disciple of Priessnitz, and one of the first writers on his system, does not claim for it a greater scope than really belongs to it; but as a healthy Branch of the Healing Art, based entirely upon physiological principles, he considers it well worth the attention of the Profession, who ought not to confound the good cause with its many bad advocates.

For Terms, etc., apply as above.

Diphtheria: Practical Observations

on, and the Treatment of, with cases.

ALSO

Pyrophosphate of Iron, Preparation

and Therapeutical Uses of.

By E. N. CHAPMAN, M.D.,

Prof. of Therapeutics and Materia Medica, Prof. of Clinical Obstetrics, and Physician in the Long Island College Hospital.

Price 35 cents each.

BAILLIERE BROTHERS, 520 Broadway, N. Y.

**The Anatomical Ball and
Socket-Jointed Leg,**

with lateral motion at the ankle, like the natural one.

ALSO:

THE U. S. ARMY AND NAVY LEG.

The latter is furnished to soldiers by the U. S. Government without charge by applying to Douglas B. Y., M.D., U. S. Commissioner for furnishing Artificial Legs to Soldiers. Offices—658 Broadway, N. Y., Rochester, N. Y., Cincinnati, O., or St. Louis, Mo.

For instructions address Dkt. BLY at nearest office.

A Fine Opportunity for a Surgeon.

—Dr. Swinburne, of Albany, N. Y., recently appointed Health Officer to the Post of New York, offers his fine residence in that city for sale for its market value, without any extra charge for its being an established place of surgical business. The house is provided with all the modern improvements, is nearly new, and built by the Doctor for his own convenience, and hence is well adapted to the wants of a physician or surgeon. There is probably no more eligible location for an aspiring young surgeon who is disposed to work his way in the world than this, and for a surgeon of reputation an excellent opportunity for a good location for practising his profession. He has also a commodious stable attached, which may be purchased if desired.

For reference please address Mr. E. Bleeker, 55 Eagle st., Albany, or Dr. John Swinburne, Quarantine, Staten Island.

was interesting to notice the affection of the soldiers for this great charity. It was a common remark among the wounded, "If the Old Sanitary is around we shan't suffer."

The Christian Commission was also early on the ground, and furnished a large variety of indispensable articles. Its agents visited the hospitals with pitchers of milk-punch, which was very grateful to the severely wounded.

Whatever may be said against these organizations, they are truly worthy of the earnest support of the people. They furnish aid that does not come within the duties of the Medical Department, and they were certainly on this occasion earlier on the ground than the latter.

MAY 15, 1864.

Army and Navy Intelligence.

CIRCULAR LETTER.

SURGEON-GENERAL'S OFFICE,
WASHINGTON, D.C., May 26, 1864.

The following Order from the War Department is respectfully furnished for your information and guidance:

WAR DEPARTMENT,
WASHINGTON, D.C., May 20, 1864.

Accounts for newspaper advertising for the Bureau of the War Department must be rendered in duplicate, and state upon their face—

- The name of the publisher or firm;
- The name of the newspaper, and the place where published;
- The dates between which inserted;
- The amount of matter and number of insertions charged for, and rate per square or line; and must be accompanied by a full schedule of the customary advertising terms of the newspaper, unless the same shall have been previously filed with the Assistant Secretary of War.

Accounts must then be verified by the officer by whom the advertisements are signed, stating that the publication was authorized by him, and the number of insertions ordered.

Advertisements copied from other papers, *without authority*, will not be paid for.

The attention of officers is directed to the fact that the practice of ordering advertisements to be inserted "till day" of sale, etc., involves a useless expenditure, in cases where the station of the officer is remote from the place of publication.

Officers issuing advertisements for publication will, at the same time, transmit copies of the same to the Assistant Secretary of War, stating the newspapers in which they are to be published, and the number of insertions ordered; and whenever only a portion of the official newspapers in any locality are selected to publish any advertisement, the officer will state his reasons for selecting the particular papers in question, and also his reasons for not advertising in the other official papers in that locality.

- By order of the Acting Surgeon-General:
(Signed) C. A. DANA,
Assistant Secretary of War.
- By Order of the Secretary of War:
C. H. CRANE,
Surgeon, U.S.A.

(GENERAL ORDERS, No. 198.)

WAR DEPARTMENT, ADJUTANT-GENERAL'S OFFICE,
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Assistant Adjutant-General.

Official:

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	Min.	Max.	Temp.	Wind.	Min.	Max.	Temp.	Wind.	Min.	Max.	Temp.	Wind.
15th.	47	48	29.99	N.E.	57	1	29.99	N.E.	48	0	29.99	N.E.
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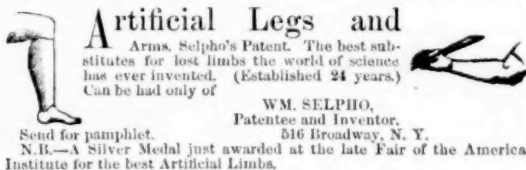
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